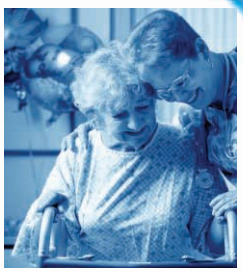
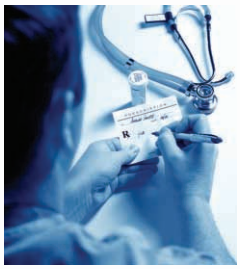
Bureau of
TennCare





Annual Report 2004-05

Looking Ahead

FY 05/06 Plans & Challenges

Reform Implementation – Phase 1: Disenrollments

The 05/06 fiscal year began with the disenrollment of the adult expansion population. The disenrollment process, including the associated appeals, is managed by the Department of Human Services (DHS).

Several state departments are working together to "soften the landing" for those being disenrolled from TennCare by funding and implementing Safety Net services.

Reform Implementation – Phase 2: Benefit Changes

As of August 1, 2005, the following changes took place for all enrollees age 21 and over:

- Convalescent care and sitter services are no longer covered.
- No prescription coverage for adults age 21 and older in the expansion population.
- Over-the-counter medication is no longer covered, except for prenatal vitamins by prescription for a pregnant enrollee.
- Prescription drug coverage for Medicaid-eligible adults who are not institutionalized is limited to no more than five prescriptions per calendar month, only two of which can be brand-name drugs. Approximately 28.5 percent of the program's 1.2 million enrollees are subject to this limit.
- Pharmacy co-pays begin for all Medicaid-eligible adults age 21 and older and TennCare Standard enrollees under age 21 with incomes at or above 100 percent FPL.
- No pharmacy co-pays charged for:
    - o Generic drugs within the monthly limit
    - o Birth control
    - o Drugs given in a medical emergency
    - o Drugs for enrollees in hospice care
    - o Drugs for pregnant women
- A "pharmacy short list" of certain drugs and supplies was created for enrollees who continue to be eligible for a pharmacy benefit, listing those specific drugs and supplies that do not count against prescription limits and that continue to be available even after the prescription limits have been hit.
- No coverage for adult (age 21 and up) dental services.
- Methadone clinic services – both detox and maintenance services – will not be covered.
- No out-of-pocket maximum for any TennCare-eligible individual.

Phase 3: Non-Pharmacy Benefit Limits

TennCare continues to await approval from CMS for reform elements slated for July 2006 implementation including limits for adults on the following services:

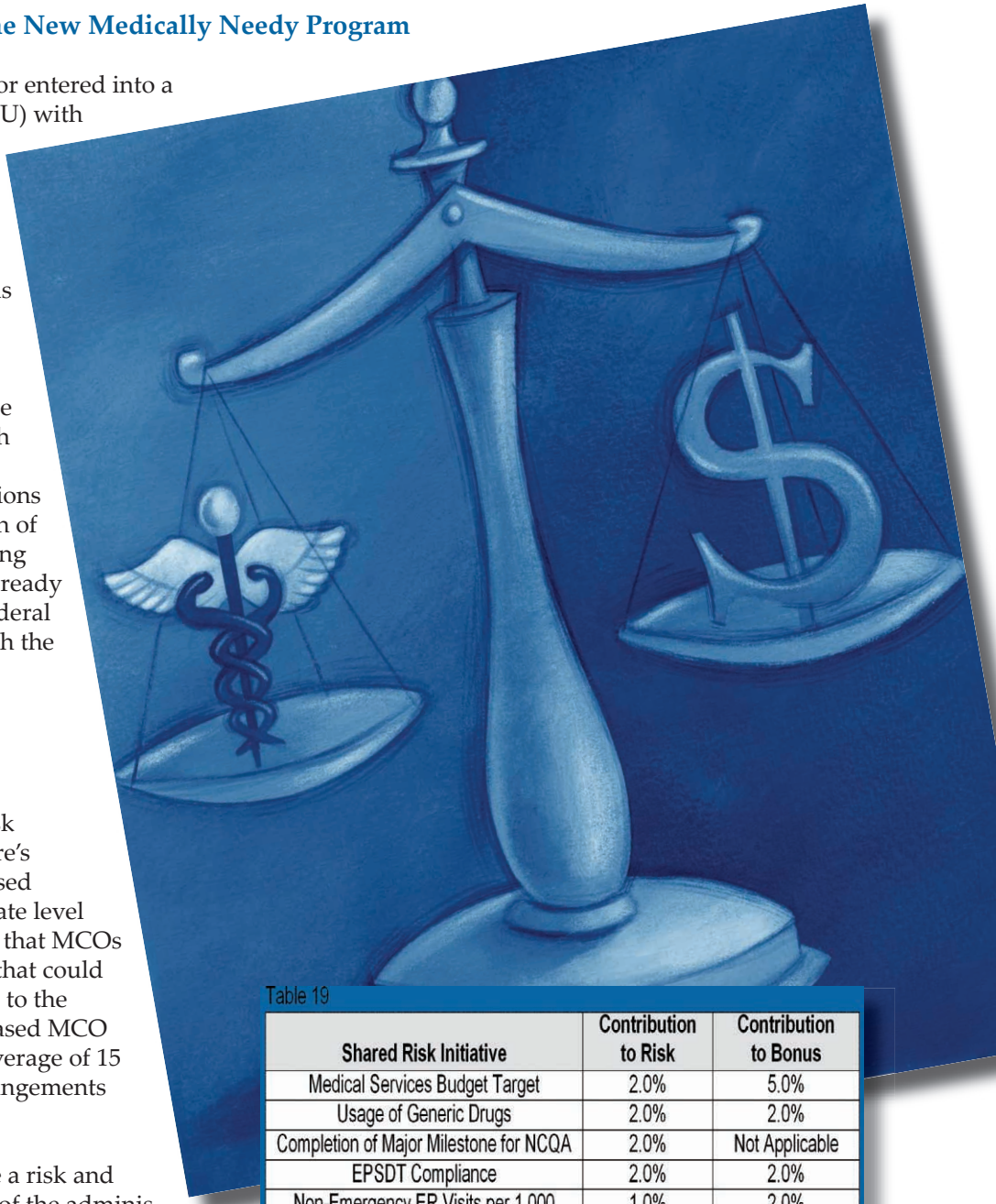
- Inpatient hospital services,
- Outpatient facility services,
- Treatment for substance abuse: 10 days detox covered, regardless of SPMI status, with a lifetime limit of $30,000 for inpatient, residential and outpatient treatment,
- Physician outpatient services, and
- Lab and X-ray services.

Implementation of the August 2005 Grier Order

Implementation of the new Grier Order took effect January 1, 2006 and involves comprehensive changes in the prior authorization process for pharmacy services, as well as significant changes in the way Tennessee processes medical appeals. In addition, the State plans to promulgate new regulations that will govern medical necessity determinations.

Implementation of the MOU – The New Medically Needy Program

Prior to the Grier hearing, the Governor entered into a Memorandum of Understanding (MOU) with one group of the lawyers representing TennCare enrollees (the plaintiff's intervenors) in which he agreed that the State would not proceed with the planned disenrollment of the Medically Needy population if the State was granted the relief it sought from the Grier consent decree.



Although the State was not granted the comprehensive relief it sought, enough relief was granted for the Governor to elect to move forward with the provisions of the MOU. This will involve creation of a new Medically Needy program during the current fiscal year. The State has already filed necessary documents with the federal government to gain authority to launch the program.

Return to Risk

Effective July 1, 2005, TennCare staff developed and negotiated a shared risk arrangement with the MCOs. TennCare's challenge to return MCOs to a risk-based arrangement was finding an appropriate level of risk while maintaining a balance so that MCOs are not placed in financial difficulties that could adversely affect the program. Adding to the difficulty of this task, TennCare decreased MCO administrative payment rates on an average of 15 percent at the same time new risk arrangements were implemented.

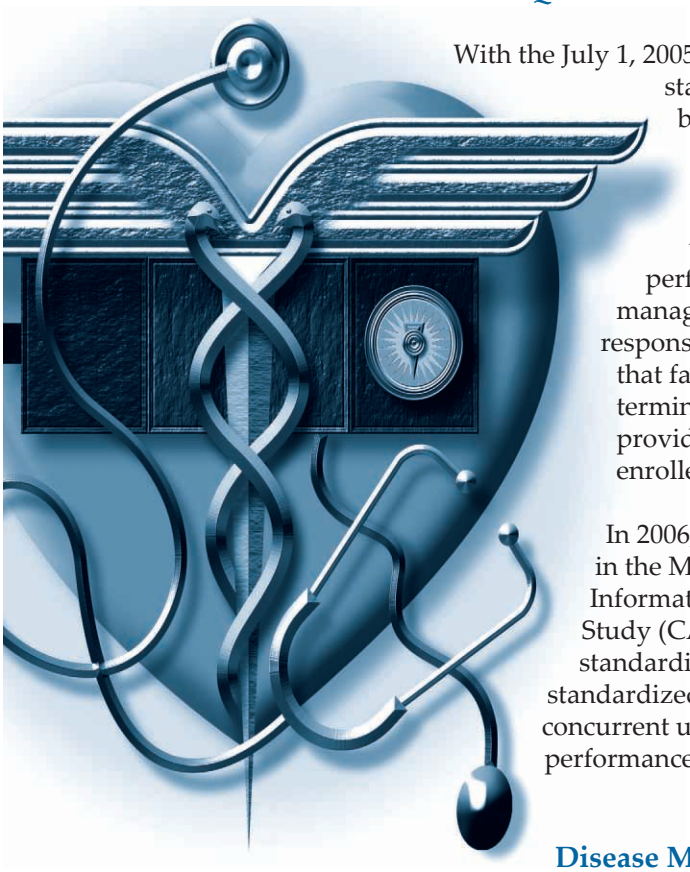
Table 19

Shared Risk Initiative	Contribution to Risk	Contribution to Bonus
Medical Services Budget Target	2.0%	5.0%
Usage of Generic Drugs	2.0%	2.0%
Completion of Major Milestone for NCQA	2.0%	Not Applicable
EPSDT Compliance	2.0%	2.0%
Non-Emergency ER Visits per 1,000	1.0%	2.0%
Inpatient Admissions per 1,000	1.0%	4.0%

The terms of this arrangement include a risk and bonus component, placing 10 percent of the administrative fee at risk and providing a bonus potential to earn 15 percent of the administrative fee for maintaining and/or meeting specified performance measures. The performance measures and percentages of risk or bonus associated with each are found in *Table 19* (above).

The cost of providing MCOs a bonus payment would be offset by the savings Tennessee would incur if the MCOs were to hit the highest performance standards. The net effect of such a payment would result in a $100 million savings for the State. The performance measures are primarily benchmarked against each individual MCO's previous experience, and failure to maintain or improve will impact the MCO financially. Should an MCO meet benchmarks that achieve bonus payouts, the savings realized by TennCare will more than pay for the bonus payouts. TennCare's intent is to return to a fully capitated risk arrangement in the future.

NCQA Accreditation



With the July 1, 2005 amendment to the MCO contract, Tennessee became the first state to mandate that all Medicaid Managed Care Organizations become accredited by the National Committee for Quality Assurance (NCQA).

NCQA is an independent, 501(c) (3) non-profit organization that assesses and scores managed care organization performance in the areas of quality improvement, utilization management, provider credentialing and member rights and responsibilities. The contracts of those managed care organizations that fail to obtain NCQA accreditation by December 31, 2006 may be terminated by TennCare. This process will leave only those MCOs providing the highest quality of care and service to provide for enrollees.

In 2006, as part of the accreditation process, the MCOs will participate in the Medicaid version of the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Study (CAHPS Survey). HEDIS is a nationally recognized set of standardized performance measures while CAHPS is a set of standardized surveys used to measure member satisfaction. The concurrent use of these measures will allow reliable comparison of the performance of TennCare MCCs to other managed Medicaid health plans.

Disease Management

Last summer, TennCare began amending the MCO contracts to set clear expectations for the statewide provision of disease management programs targeting a minimum of five (5) health conditions: high risk pregnancy, diabetes, asthma, congestive heart failure and obesity. These conditions were selected because of their prevalence in the TennCare population and the significant potential that exists to improve quality of care through the use of disease management interventions. These efforts represent a substantial step toward improved patient outcomes by promoting health care, provider adherence to best practice guidelines, and educating and engaging patients in the important role they play in managing their own health.

"Soft" Benefit Limits

With the implementation of reform, TennCare implemented "hard" benefit limits. Hard limits refer to limits that cannot be exceeded for any reason. Because the Grier Consent Decree did not allow Tennessee to implement an effective prior authorization system, hard limits were felt to be the only way to control costs by reducing the numbers of services delivered. In reality, certain exceptions were built into the initial phase of reform, in the form of "short lists". The pharmacy short list includes certain drugs that do not count against the 5 prescription / 2 brand limit and are available to enrollees even after the limit has been hit. A similar list exists for non-pharmacy services. Despite the existence of these short list exceptions, there is a desire to expand the ability to make exceptions to the benefit limits for enrollees with extraordinary medical needs. If and when legal conditions permit, TennCare will pursue implementation of "soft" limits.

NMPI and Preferred Drug List

On July 1, 2005, TennCare joined the National Medicaid Pooling Initiative (NMPI). In comparison to the supplemental rebate contracts negotiated in late 2003, the NMPI significantly increases the number of therapeutic classes with supplemental rebates, resulting in the potential for additional cost savings for the TennCare program. In addition, the supplemental rebate contracts negotiated through the NMPI lock in prices for a three-year period, resulting in price protection.

As a result of the expanded therapeutic classes with available rebates, the Preferred Drug List (PDL) has been expanded and an updated PDL was rolled out during the months of July-December, 2005. Select classes of medications were

gradually grandfathered each month through the end of December 2005. This allowed time for physicians to evaluate their patients, change treatment to a preferred agent, or apply for prior authorization. As market share shifts to the preferred agents on the PDL, additional cost savings are expected to be seen as a result of contracted supplemental rebates for these medications.

Home and Community Based Services (HCBS) Waiver Changes

Home and community based services (HCBS) are available in limited quantities for those people with developmental delays, mental retardation and/or elderly who would qualify for ICF admission, but wish to remain in their homes and receive services. The services needed and received by the patient must be less costly than admission to a long term care center. HCBS plans are operated through waivers with CMS.

For both programs, a $291,000 Real Choice grant will be used to re-design the current Pre-Admission Evaluation (PAE) intake form, with the goal to develop an intake document that is useful for both institutional and non-institutional placements. Plans are also underway to pilot a HCBS program to integrate HCBS services into TennCare's managed care program in an effort to promote continuity of care.

In addition to the PAE intake process improvements listed above, the TennCare Bureau has launched several initiatives to improve the existing HCBS program, including:

- Petitioning the federal government to expand the number of HCBS slots available to enrollees
- Creating greater flexibility in our HCBS rules to encourage expansion of the program
- Creating a presumptive eligibility process to make it easier for enrollees to become enrolled in an HCBS program
- Recommending increased funding for HCBS programs by $6.4 million total new dollars

The TennCare program will continue its commitment to improving HCBS programs across the state in the coming year to ensure proper services are available to enrollees in home and community-based settings.

Medicare Part D

Medicare Part D took effect on January 1, 2006, giving all Medicare eligibles a drug benefit. With the implementation of Part D, the federal government has assumed responsibility for drug benefits for the Medicaid/ Medicare dual eligibles.

Medicaid Reform at the National Level

Medicaid spending has been growing exponentially. In the four years between 2000 and 2004, federal Medicaid spending increased by nearly $60 billion - an increase from $117.9 billion to $176.2 billion. The federal Congressional Budget Office estimates that federal Medicaid spending will reach $193 billion in 2006.

States are attempting to keep up with spiraling costs. Medicaid spending is now the largest component of state budgets, having passed education spending for the first time in history in 2003. In fact, in 2005, Tennessee's Medicaid expenditures represented 26.34 percent of Tennessee's Department of Revenue's tax collections. Most reform efforts around the country have taken place at the state rather than the federal level. The primary reform efforts that have

occurred at the national level to date have been introduction of new waiver options for states, such as HIFA waivers.

The most recent Congressional budget agreement called for a $10 billion slowing of the Medicaid rate of growth over the next five years and established a Medicaid Commission to make recommendations for how to achieve these savings. The Secretary of Health and Human Services signed a charter for the Commission on May 19, 2005, and shortly thereafter appointed the members. The purpose of the Commission is to produce two reports:

- The first report, due on September 1, 2005, was submitted containing a detailed proposal for achieving $10 billion in reductions in the rate of federal Medicaid spending over the next five years. Several of the recommendations from this report were approved as part of the Budget Reconciliation Act passed by Congress and later signed by the president in early 2006.
- By December 31, 2006, the Commission will complete a report containing a detailed proposal and recommendations for modernizing the Medicaid program on a long-term basis.

Move to New Building

The downtown Nashville building that has housed TennCare, and the state's Medicaid program prior to the creation of TennCare for decades was acquired by the federal government last year to make room for a new federal courthouse.

Having been displaced by the federal government, the state contracted for the construction of an office building to house all TennCare staff. More than 500 staff and major contractors relocated to the 200,000 square foot facility during the summer of 2005, representing the single largest facility relocation in the state's history.

Conclusion

The past year has included difficult, but necessary decisions, in the TennCare program. The year also included several notable milestones – moving the managed care network back to risk sharing, preserving coverage for 100,000 enrollees, winning the battle over runaway pharmacy costs and fighting for and achieving relief from long-standing consent decrees – to name a few. The willingness to tackle these difficult challenges and make the difficult decisions has resulted in a program that is financially viable and remains among the most generous in the nation.

The Bureau will take this momentum forward next year and continue to improve the operation of the program while every day meeting the health care needs of our enrollees and acting as effective stewards of taxpayer dollars. ■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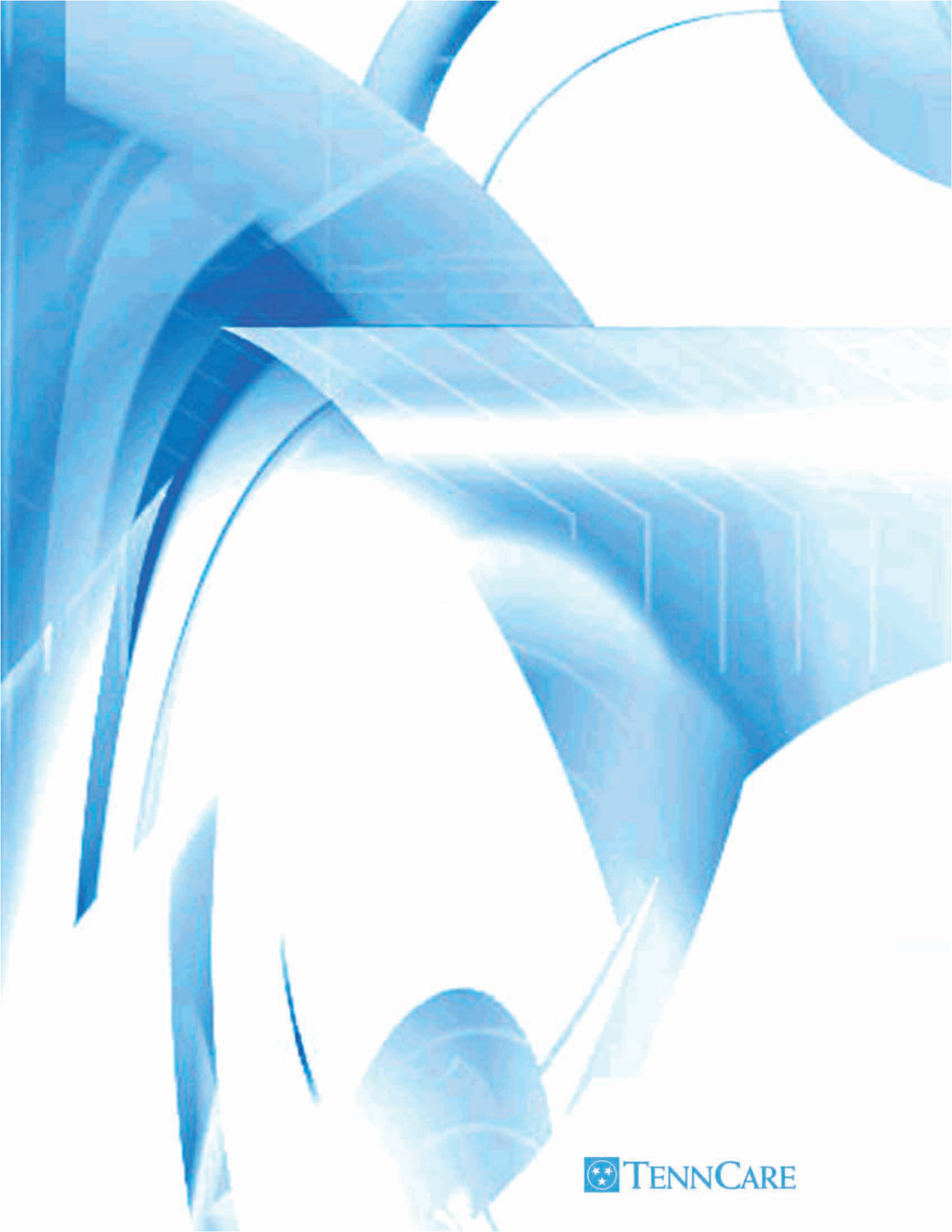
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